MIC Choice MN 750
Rx 3-tier

MEDICA CHOICE
SUMMARY OF BENEFITS

City of Saint Paul
January 1, 2009
Group #61652 and 16009

Partial Listing of Covered Services	Medica Choice In-network Benefits	Out-of-Network Benefits*
Annual Deductible	$750/member $1,500/family	$1,000/member $2,000/family
Annual Out-of-Pocket Maximum	$3,000/member	$3,000/member
Lifetime Maximum	$5,000,000	
	When you receive covered services after deductible has been met, MIC PAYS:	**When you receive covered services after deductible has been met, MIC PAYS:**
Preventive Care • **Routine Physical & Eye Exams** • **Immunizations, Well Child Care, Cancer Screenings and Allergy Shots**	*The deductible does not apply to these services.* 100% 100%	 No Coverage 70%
Office Visits • **Illness or Injury** • **Chiropractic Care** • **Physical, Occupational & Speech Therapy** • **Mental Health and Substance Abuse**	 80% 80% 80% 80% for individual therapy or 90% for group therapy.	 70% 70% *Limited to 15 visits per member, per year.* 70% 70%
Prescription Drugs *Up to a 31-day supply per prescription*	*The deductible does not apply to these services.* 100% after $25 copayment for generic formulary, 100% after $65 copayment for brand formulary and 100% after $80 copayment for non-formulary drugs.	60%. Member pays the greater of 40% or a $80 copayment per prescription unit.
Specialty Prescription Drugs *Up to a 31-day supply per prescription for specialty prescription drugs received from a designated specialty pharmacy.*	*The deductible does not apply to these services.* Formulary: 80%. Member does not pay more than $200 per prescription unit or refill.	No Coverage
Inpatient Hospital Services • **Facility** • **Physician** • **Mental Health and Substance Abuse**	 80% 80% 80%	*Limited to 120 days per member, per year.* 70% 70% 70%
Outpatient Hospital Services • **Facility** • **Physician**	 80% 80%	 70% 70%
Lab and Pathology	80%	70%
X-Ray and Other Imaging	80%	70%
Urgent or Emergency Care • **Urgent Care Center** • **Hospital Emergency Room** • **Emergency Ambulance**	 80% 80% 80%	 80% after in-network deductible. 80% after in-network deductible. 80% after in-network deductible.
Durable Medical Equipment and Prosthetics	80%	70%
Home Health Care	80%	70%

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Out of Network Coverage

* Coverage is limited to the non-network provider reimbursement amount (as defined in your Certificate of Coverage) after deductible is met.
* If you decide to utilize your Out-of-Network Benefits, you may pay more than you would for In-Network Benefits. The amount you pay could include a percentage coinsurance, a fixed dollar copayment and/or deductible amount. In addition, if the amount that your non-network provider bills you is more than the non-network provider reimbursement amount (as defined in your Certificate of Coverage) **you are responsible for paying the difference,** and such difference will not be applied toward the Out-of-Pocket Maximum.

Exclusions and Limitations to Coverage

The following is a list of some of the services and supplies that are excluded from coverage. When you enroll, the Certificate of Coverage you receive will provide a more complete and detailed list of exclusions. Please refer to your Certificate of Coverage for specific information about excluded services or supplies.

- Cosmetic Surgery.
- Refractive eye surgery.
- Exams for employment, insurance, administrative proceedings, research or licensure.
- Personal convenience items and some non-durable supplies.
- A drug, device or medical treatment or procedure that is investigative or not a covered health service.
- Custodial supportive care and self-care or self-help training.
- Educational classes, programs or seminars.
- Services prohibited by law or regulation.
- Services for which coverage is available under worker's compensation, employer liability or any similar law.

Contact **Customer Service at 952-945-8000** (Minneapolis/St. Paul metro area), **952-992-3190** (Minneapolis/St. Paul metro area individuals with hearing impairments), **800-952-3455** (outside of Minneapolis/St. Paul metro area), or **800-841-6753** (outside of Minneapolis/St. Paul metro area individuals with hearing impairments) for more information or answers to specific questions.

This health care plan may not cover all your health care expenses; read your Certificate of Coverage carefully to determine which expenses are covered. This is a benefit summary only and does not outline all of your benefits. If there is a discrepancy between information in this summary and your Certificate of Coverage, the Certificate of Coverage will take precedence in determining your benefits.

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